MEL CARNAHAN
GOVERNOR

MISSOURI
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
P.O. BOX 6500
JEFFERSON CITY
65102-6900

RELAY MISSOURI
for hearing and Speech impaired
TEXT TELEPHONE
1-800-735-2966
VOICE
1-800-735-2466

573/751-6922

April 29, 1998

Nancy Goetschius
Missouri Demonstration Project Officer
Health Care Financing Administration
Office of State Health Reform Demonstrations
7500 Security Blvd., C-3-18-26
Baltimore, MD 21244-1850

Dear Ms. Goetschius:

Enclosed you will find four copies of Missouri's MC+ Demonstration Design Operational Protocol Guidelines related to our 1115 waiver. I have also forwarded three copies of this document to Richard Brummel.

If you have any questions regarding this information please do not hesitate to contact me.

Sincerely,

/S/

Gregory A. Vadner
Director

GAV:kl

Enclosures (4)

cc: Richard Brummel (with enclosures)

Missouri Medicaid

1115 Waiver

MC+ Demonstration Design

Operational Protocol Guidelines

Mel Carnahan
Governor

Submitted to the
U.S. Department of Health & Human Services
April 30, 1998

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demonstration, subsequent changes to the protocol which are the result of major changes in policy or operating procedures should be submitted no later than 90 days prior to the date of implementation of the change(s) for approval by HCFA.

1.

THE ORGANIZATIONAL AND STRUCTURAL ADMINISTRATION THAT WILL BE IN PLACE TO IMPLEMENT, MONITOR, AND RUN THE DEMONSTRATION, AND THE TASKS THAT EACH WILL PERFORM.

The MC+ program is administered by the Division of Medical Services office located in Jefferson City, Missouri. The division has a managed care section in the Service Delivery Unit which has primary responsibility for operation of the MC+ program. In addition, a regional administrator is assigned to each MC+ region. Regional administrators are the primary contact between the division and the various health plans contracted to provide MC+ services. Please see Attachment 1, DMS Organizational Charts.

2.

THE ORGANIZATION OF MANAGED CARE NETWORKS AND THE CRITERIA PROCEDURES FOR DETERMINING ADEQUATE MANAGED CARE PROVIDER CAPACITY BY COUNTY, AS WELL AS THE PROCESS AND CRITERIA APPLIED FOR PROVIDER SELECTION.

Access will be guaranteed through the use of the MC+ 1915(b) system. MC+ contracts require network adequacy standards be met. Adequacy standards are referenced in item 2.2, paragraph 2.2.2 of the Central and Eastern MC+ Request for Proposals (RFP), and Part Two, Section II, paragraph 2 in the Western and Northwestern MC+ RFPs. Please see Attachment 2, MC+ Contracts. Where MC+ is not yet operating, the full range of Medicaid fee-for-service providers will be available. All access requirements to the 1115 waiver.

The health plan must have in place sufficient administrative staff and organizational components to comply with all program standards. The information regarding health plan staffing is referenced in item 2.2, paragraph 2.2.1 of the Central and Eastern RFPs, and Part II, Section II, paragraph 1 in the Western and Northwestern RFPs.

3.

A COMPLETE DESCRIPTION OF MEDICAID SERVICES COVERED UNDER THE DEMONSTRATION, INCLUDING PHOSE SUBJECT TO CAPITATION AND THOSE OTHERWISE REIMBURSED.

A health plan must agree to assume the responsibility for all covered medical conditions of each MC+ member as of the effective date of coverage under its contract. The health plan must agree to make available the comprehensive benefit package to program members. Services must be provided according to the medical needs of the individual. Limitations on specific services may be established as long as the health plan provides alternative services that are medically appropriate. The health plan must have a process for allowing exceptions to these limitations. Health plans may develop criteria by which the health plan will review future treatment options, set prior authorization criteria, or exercise other administrative options for the health plan's administration of medical care benefits. It is the responsibility of the health plan to determine whether or not a service furnished or proposed to be furnished is reasonable and medically necessary for the diagnosis or treatment of illness or injury, to improve the function of a malformed body member,, or to minimize the progression of disability, in accordance with accepted standards of practice in the medical community of the area in which the health services- are rendered; and the service could not have been omitted without adversely affecting the member's condition or the quality of medical care rendered; and the service is furnished in the most appropriate setting.

If a health plan requires prior authorization for pharmacy products,, the health plan must provide response by telephone or other telecommunication device within 24 hours of a request for prior authorization. Approvals must be granted for any medically accepted use. Medically accepted use is to be defined as any use for a drug product which is approved under the Federal Food, Drug, and Cosmetic Act, which appears in peer-reviewed literature or which is accepted by one or more of the following compendia: The American Hospital Formulary Service - Drug Information, The American Medical Association Drug Evaluations, and the United States Pharmacopeia - Drug Information. Health plans must provide for the dispensing of at least a 72-hour supply of a drug product that requires prim authorization in an emergency situation.

Uninsured Children Below 200 Percent Under Title XIX, Coordinated with Title XXI Funding

Covered Groups

Missouri proposes that all uninsured children with net family income up to 200 percent of the federal poverty level (300 percent gross income) be covered under a Medicaid expansion. The Medicaid expansion will occur under a Title XIX 1115 waiver. Children will include individuals age birth through age 18. No new eligible will be excluded because of preexisting illness or condition.

There will be protections against dropping or foregoing private coverage, including a six month waiting period and insurance availability screen through the Division of Medical Services Health Insurance Premium Payment (HIPP) program.

- Children of parents who dropped available private health insurance coverage within the last six months will have a six month waiting period for Medicaid coverage. Exceptions to this limitation in cases where prior coverage ended due to reasons unrelated to the availability of government financed health insurance shall include, but not be limited to:
  - Loss of employment due to factors other than voluntary termination;
  - Change to a new employer that does not provide an option for dependent coverage; or
  - Expiration of COBRA coverage period.
- Where economically cost effective, the state will use the HIPP program to obtain available coverage through available commercial insurance, and any non-covered services that are included in the Medicaid package will be obtained through MC+, or fee-for-service where MC+ is not available.

Covered Services

Children will receive the Medicaid package of essential medically necessary health services. Non-emergent medical transportation will not be a covered service. Under fee-for-service reimbursement, prescription drugs will be subject to the national drug rebate program. Under capitated reimbursement, managed *care* rates will be developed based on fee-for-service drug expenditures, minus claimed drug rebates. Fee-for-sewice will be utilized in regions where MC+ is not yet available. When MC+ begins in these areas, this population will be enrolled in managed care.

Income Determination

Income will be determined by looking at the total gross income available to the children for whom the application is being made. The current assistance group definitions used by Missouri for Medicaid budgeting will be followed, A standard income disregard equal to 100 percent of the federal poverty level will be made from the gross income figure. The net income figure will be compared to. 200 percent of the federal poverty level to determine if the child(ren) is (are) eligible. To be eligible this net figure must not exceed 200 percent of the federal poverty level for children.

Cost Sharing

There will be no cost sharing for eligible children.

Crowd Out Protections

It is important to be concerned that this program does not "crowd out" private insurance options. The following measures will help address this issue,

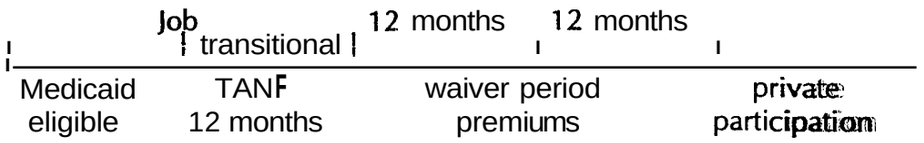
- Uninsured is defined as an individual who has not had employer-subsidized health care insurance coverage for six months prior to application for payment of health care.
- There will be a six month look back period for health insurance when determining eligibility. Children of parents who dropped available private health insurance coverage within the last six months will have a six month waiting period for Medicaid coverage. Exceptions to this limitation in cases where prior coverage ended due to reasons unrelated to the availability of government financed health insurance shall include, but not be limited to:
  - Loss of employment due to factors other than voluntary termination;
  - Change to a new employer that does not provide an option for dependent coverage; or
  - Expiration of COBRA coverage period.
- Non-emergent transportation will not be covered. This benefit is so unheard of in any health insurance plan that its inclusion would serve as a significant incentive for the dropping of private coverage
- Crowd out will be evaluated yearly to determine if additional protections are warranted. If crowd out does become a problem the state will develop additional anti-crowd out measures as warranted by the scope and nature of the problem. Additional options may include:
  - Adding an insurance availability test to preclude participation;
  - Lengthening the look back period;
  - Implementing cost sharing provisions;

- Moving to once yearly open enrollment periods for children with family income over 200 percent of gross federal poverty level; and
- Other measures designed to efficiently deal with what the research finds.

TANF Transitional Adults for an Additional Two Years Under Title XIX

Covered Groups

Adults transitioning off of Temporary Assistance (TANF) will be eligible to participate in Missouri's expanded Medicaid program if they would otherwise not be insured or Medicaid eligible. To be eligible a person must have met the eligibility requirements and exhausted their twelve months of transitional Medicaid coverage. They would move directly from the twelfth month of transitional to the working parents Medicaid coverage. This coverage will be available through state and federal funding for two years. To remain eligible a person must remain employed and have a Medicaid eligible child in the home. The family income must remain under 300 percent of the federal poverty level (200 percent net budgetable income) to maintain coverage. Resources will be disregarded. Eligibility will be reviewed on an annual basis.



After the initial two year program, beneficiaries in an area with MC+ will have the option to continue their health coverage by paying the premium cost directly to the health plan for the length of the 1115 waiver. This will be at the same rate that the state pays per member for coverage during the year. Adjustments to these private participation rates will occur as the state's rates change. The state and federal government will not financially participate in cost sharing in this arrangement, but the state will require such coverage be available in its MC+ contracts. The health plans will be required to allow employers to pay part or all of this cost on behalf of eligible employees. MC+ health plans will be required to accept payments on a monthly basis. If payment is delinquent by more them 15 calendar days, a health plan may take appropriate action including termination of coverage. Before termination of coverage the health plan must send an overdue notice reminding the participant of the importance of timely payment and the date-certain deadline to receive payment or lose coverage.

Where economically cost effective, the state will use the Health Insurance Premium Payment program to obtain available coverage through available commercial insurance. Any noncovered services that are included in the waiver

services package will be obtained through MC+, or fee-for-service where MC+ is not available.

Covered Services

Coverage for adults in the expanded eligibility categories will be bid by health plans according to MC+ regions but with a more commercially-oriented benefit package than that provided to children. Services will be provided fee-for-service where MC+ is not yet available.

Services will include a package of benefits equivalent to that currently offered State of Missouri employees. The covered services for this group in the waiver are:

- Allergy injections
- Ambulance service – Ground services covered at 100 percent if medically necessary or with prior approval; air services covered at 100 percent in emergency cases or with prior approval. Non-emergent medical transportation is not covered.
- Contraceptives
- Dental care – Treatment to reduce trauma as a result of accidental injury or oral surgery when medically necessary
- Durable medical equipment
- Emergency care
- Eye and vision care – Treatment of disease or to reduce trauma as a result of an accident
- Hearing aids and testing – Hearing aids covered once every two years
- Home health care – Covered when authorized by primary care provider
- Hospice care
- Hospital benefits for mental and nervous disorder – Must be arranged by primary care provider
- Hospital benefits for alcohol and drug abuse – Must be arranged by primary care provider
- Hospital room and board – Must be arranged by primary care provider
- injections
- Maternity coverage – Prenatal visits, delivery costs, and routine post-natal visits are covered
- Non-elective surgery
- Organ transplants – The following organ transplants covered at 100 percent: bone marrow, cornea, kidney, liver, heart, and lung when: (1) neither experimental or investigational, and (2) medically necessary as determined by primary care provider.
- Outpatient diagnostic lab and x-ray – Provided in full

- Outpatient mental and nervous disorder – Maximum 20 visits per year. Group therapy may be provided on a two for one exchange (i.e., any combination of 40 group sessions and/or 20 individual sessions).
- Oxygen (outpatient)
- Physical therapy and rehabilitation services
- Physician services
- Prescription drugs (Under fee-for-service reimbursement, prescription drugs will be subject to the national drug rebate program. Under capitated reimbursement, managed care rates will be developed based on fee-for-service drug expenditures, minus claimed drug rebates.)
- Preventative services – Annual physical exams, immunizations, pap smears; mammograms, well-woman exams
- Skilled nursing facility – Benefits are limited to 120 days per calendar year, provided in full (subject to medical necessity)

There will be no yearly individual benefit maximum.

Cost Sharing

Premiums at the time of services will apply to increase participant responsibility, move coverage closer to that found in the commercial market, and help reduce the chance of crowd out. Premiums will be $10 at the time of each provider visit and *$5* per prescription and the professional dispensing fee. These amounts were chosen because they are consistent with the state employee's health plan and with many other commercial plans. Failure to pay the cost sharing may result in denial of service.

Crowd Out Protections

While the issue of crowd out is not addressed in the Title XIX law, we believe in today's health care environment it is important to address.

- Cost sharing is a significant "crowd out" protection, Since most private plans require cost sharing, even for people in minimum wage jobs, it makes no sense to eliminate them here. in fact, many commercial plans require *both* monthly premiums and co-pays at time of service. To avoid cost sharing here would create the strongest of incentives to drop or avoid private coverage.
- Comparability – Move covered services close to that found in the commercial market. We are trying to move individuals into the mainstream, which includes a covered service package comparable to the commercial market. We have modeled our package after those in the state employee plan. By offering a commercial benefit package instead of one with additional benefits we have eliminated another incentive to drop or avoid-private health insurance coverage.

Uninsured Noncustodial Parents Below 100 Percent Paying Child Support Under Title XIX

Covered Groups

Uninsured non-custodial parents with income up to 100 percent of the federal poverty level who are actively paying child support at or above their legally obligated amount will be eligible for Medicaid to the extent that the coverage would not cause the costs to exceed budget neutrality. The non-custodial parent must remain current in their child support obligation to maintain Medicaid eligibility. The state will monitor that child support is paid before establishing eligibility for that month. A person must apply in order to receive Medicaid services. Income levels will be reviewed on an annual basis. There will be no retroactive eligibility (no prior quarter coverage). Coverage will be available for a maximum of two consecutive years.

Where economically cost effective, the state will use the Health Insurance Premium Payment program to obtain available coverage through available commercial insurance. Any noncovered services that are included in the waiver services package will be obtained through MC+, or fee-for-service where MC+ is not available.

Covered Services

Coverage for adults in this expanded eligibility category will be bid by health plans according to MC+ regions but with a more commercially-oriented benefit package than that provided to children through Medicaid. Services will be provided fee-for-service where MC+ is not yet available.

Services will include a package of benefits equivalent to that currently offered State of Missouri employees. The covered services for this waiver group are:

- Allergy injections
- Ambulance service – Ground services covered at 100 percent if medically necessary or with prior approval; air services covered at 100 percent in emergency cases or with prior approval. Non-emergent medical transportation is not covered.
- Contraceptives
- Dental care – Treatment to reduce trauma as a result of accidental injury or oral surgery when medically necessary
- Durable medical equipment
- Emergency care
- Eye and vision care – Treatment of disease or to reduce trauma as a result of an accident
- Hearing aids and testing –-Hearing aids covered once every two years

- Home health care – Covered when authorized by primary care provider
- Hospice care
- Hospital benefits for mental and nervous disorder – Must be arranged by primary care provider
- Hospital benefits for alcohol and drug abuse – Must be arranged by primary care provider
- Hospital room and board – Must be arranged by primary care provider
- Injections
- Maternity coverage – Prenatal visits, delivery costs, and routine post-natal visits are covered
- Nonelective surgery
- Organ transplants – The following organ transplants covered at 100 percent: bone marrow, cornea, kidney, liver, heart, and lung when: (1) neither experimental or investigational, and (2) medically necessary as determined by primary care provider.
- Outpatient diagnostic lab and x-ray – Provided in full
- Outpatient mental and nervous disorder – Maximum 20 visits per year. Group therapy may be provided on a two for one exchange (i.e., any combination of 40 group sessions and/or 20 individual sessions).
- Oxygen (outpatient)
- Physical therapy and rehabilitation services
- Physician services
- Prescription drugs (Under fee-for-service reimbursement, prescription drugs will be subject to the national drug rebate program. Under capitated reimbursement, managed care rates will be developed based on fee-for-service drug expenditures, minus claimed drug rebates.)
- Preventative services – Annual physical exams, immunizations,, pap smears; mammograms, well-woman exams
- Skilled nursing facility – Benefits are limited to 120 days per calendar year, provided in full (subject to medical necessity)

There will be no yearly individual benefit maximum.

Budgeting and deduction for eligibility will be comparable to current Medicaid rules for this covered group.

Should say current rules apply

***Cost* Sharing**

Premiums at the time of services will apply to increase participant responsibility, move coverage closer to that found in the commercial market, and help reduce the change of crowd out. Premiums will be $10 at the time of each

provider visit and $5 per prescription and the professional dispensing fee.. These amounts were chosen because they are consistent with the state employee's health plan and with many other commercial plans. Failure to pay the cost sharing may result in denial of service.

Crowd **Out Protections**

While the issue of crowd out is not addressed in the Title XIX law, we believe in today's health care environment it is important to address.

- Cost sharing is a significant "crowd out" protection. Since most private plans require cost sharing, even for people in minimum wage jobs, it makes no sense to eliminate them here. In fact, many commercial plans require both monthly premiums and co-pays at time of service. This would create the strongest of incentives to drop or avoid private coverage.
- Comparability - Move covered services close to that found in the commercial market. We are trying to move individuals into the mainstream, which includes a covered service package comparable to the commercial market. We have modeled our package after those in the state employee plan.
- Uninsured is defined as an individual who has not had employer-subsidized health care insurance coverage for six months prior to application for payment of health care.
- There will be a six month look back period for insurance coverage when determining eligibility. If a person has been covered by health insurance in the last six months and dropped coverage, they will not be eligible for this program until six months after coverage was dropped. Exceptions to this limitation in cases where prior coverage ended due to reasons unrelated to the availability of government financed health insurance shall include, but not be limited to:
  - Loss of employment due to factors other than voluntary termination;
  - Change to a new employer that does not provide an option for dependent coverage; or
  - Expiration of COBRA coverage period.

Parents' Fair Share Under Title XIX

Covered Groups

Certain uninsured noncustodial parents actively participating in the Missouri Parents' Fair Share program will be eligible for Medicaid under this waiver amendment. Continued participation and cooperation in Parents' Fair Share is mandatory for continued Medicaid eligibility and the noncustodial parent must be uninsured.

Parents' Fair Share is a program operated by the Missouri Division of Child Support Enforcement. The program assists noncustodial parents find employment, meet their child support obligation, become self sufficient, and improve their relationship with their children.

To be eligible for Parents' Fair Share the non-custodial parent must meet the following requirements:

- Must reside in the State of Missouri;
- Must have one child receiving Temporary Assistance benefits, food stamps, or Title XIX benefits in the State of Missouri (the child cannot reside with the noncustodial parent);
- Must be the legal or presumed parent of the child (paternity can not be in question); and
- Must be unemployed or underemployed (working fewer than 40 hours a week at minimum wage or less).

The Parents' Fair Share program is available in all counties in the State of Missouri. Participation is voluntary, but a noncustodial parent may be ordered into the program by the courts as a condition of probation for failure to pay child support. For fiscal year 1997 the estimated Parents' Fair Share enrollment is 807.

Where economically cost effective, the state will use the Health Insurance Premium Payment program to obtain available coverage through available commercial insurance. Any noncovered services that are included in the waiver services package will be obtained through MC+, or fee-for-service where MC+ is not available.

Covered Services

Coverage for adults in the expanded eligibility categories will be hid by health plans according to MC+ regions but with a more commercially-oriented benefit package than that provided to children. Services will be provided: fee-for-service where MC+ is not yet available.

Services will include a package of benefits equivalent to that currently offered State of Missouri employees, plus non-emergent medical transportation. The covered services for this group in the waiver are:

- Allergy injections
- Ambulance service – Ground services covered at 100 percent if medically necessary or with prior approval; air services covered at 100 percent in emergency cases or with prior approval.
- Contraceptives
- Dental care – Treatment to reduce trauma as a result of accidental injury or oral surgery when medically necessary
- Durable medical equipment
- Emergency care
- Eye and vision care – Treatment of disease or to reduce trauma as a result of an accident
- Hearing aids and testing – Hearing aids covered once every two years
- Home health care – Covered when authorized by primary care provider
- Hospice care
- Hospital benefits for mental and nervous disorder – Must be arranged by primary care provider
- Hospital benefits for alcohol and drug abuse – Must be arranged by primary care provider
- Hospital room and board – Must be arranged by primary care provider
- Injections
- Maternity coverage – Prenatal visits, delivery costs, and routine post-natal visits are covered
- Nonelective surgery
- Nonemergent medical transportation surgery
- Organ transplants – The following organ transplants covered at 100 percent: bone marrow, cornea, kidney, liver, heart, and lung when: (1) neither experimental or investigational, and (2) medically necessary as determined by primary care provider.
- Outpatient diagnostic lab and x-ray – Provided in full
- Outpatient mental and nervous disorder – Maximum 20 visits per year. Group therapy may be provided on a *two* for one exchange (i.e., any combination of 40 group sessions and/or 20 individual sessions).
- Oxygen (outpatient)
- Physical therapy and rehabilitation services
- Physician services
- Prescription drugs (Under fee-for-service reimbursement, prescription drugs will be subject to the national drug rebate program. Under capitated reimbursement, managed care rates will be developed based on fee-for-service drug expenditures, minus claimed drug rebates.)
- Preventative services – Annual physical exams, immunizations, pap smears; mammograms, well-woman exams

- Skilled nursing facility – Benefits are limited to 120 days per calendar year, provided in full (subject to medical necessity)

There will be no yearly individual benefit maximum.

***Cost* Sharing**

There will be no cost sharing for Parents' Fair Share participants because to be eligible for Parents' Fair Share, the noncustodial parent must be unemployed or working fewer than 40 hours a week at minimum wage or less.

Crowd Out Protections

While the issue of crowd out is not addressed in the Title XIX law, we believe in today's health care environment it is important to address.

- Comparability – Move covered services close to that found in the commercial market. We are trying to move individuals into the mainstream, which includes a covered service package comparable to the commercial market. We have modeled our package after those in the state employee plan.
- Uninsured is defined as an individual who has not had employer-subsidized health care insurance coverage for six months prior to application for payment of health care.
- There will be a six month look back period for health insurance coverage when determining eligibility. If a person has been covered by health insurance in the last six months and dropped coverage, they will not be eligible for this program until six months after average was dropped. Exceptions to this limitation in cases where prior coverage ended due to reasons unrelated to the availability of government financed health insurance shall include, but not be limited to:
  - Loss of employment due to factors other than voluntary termination;
  - Change to a new employer that does not provide an option for dependent coverage; or
  - Expiration of COBRA coverage period.

Uninsured Custodial Parents Below 100 Percent Under Title XIX

Covered Groups

Uninsured custodial parents with income up to 100 percent of the federal poverty level will be eligible for Medicaid to the extent that the coverage would not cause the costs to exceed budget neutrality. A person must apply in order to receive Medicaid services. Eligibility will be verified on an annual basis, and there will be no retroactive eligibility (no prior quarter coverage).

Where economically cost effective, the state will use the Health Insurance Premium Payment program to obtain available coverage through available commercial insurance. Any noncovered services that are included in the waiver service package will be obtained through MC+, or fee-for-service where MC+ is not available.

Covered Services

Coverage for adults in this expanded eligibility category will be bid by health plans according to MC+ regions but with a more commercially-oriented benefit package than that provided to children through Medicaid. Services will be provided fee-for-service where MC+ is not yet available.

Services will include a package of benefits equivalent to that currently offered State of Missouri employees. The covered services for this group in the waiver are:

- Allergy injections
- Ambulance service – Ground services covered at 100 percent if medically necessary or with prior approval; air services covered at 100 percent in emergency cases or with prior approval. Non-emergent medical transportation is not covered.
- Contraceptives
- Dental care – Treatment to reduce trauma as a result of accidental injury or oral surgery when medically necessary
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- Hospital benefits for alcohol and drug abuse – Must be arranged by primary care provider

- Hospital room and board – Must be arranged by primary care provider
- Injections
- Maternity coverage – Prenatal visits, delivery costs, and routine post-natal visits are covered
- Nonelective surgery
- Organ transplants – The following organ transplants covered at 100 percent: bone marrow, cornea, kidney, liver, heart, and lung when: (1) neither experimental or investigational, and (2) medically necessary as determined by primary care provider.
- Outpatient diagnostic lab and x-ray – Provided in full
- Outpatient mental and nervous disorder – Maximum *20* visits per year. Group therapy may be provided on a two for one exchange (i.e., any combination of 40 group sessions and/or 20 individual sessions),
- Oxygen (outpatient)
- Physical therapy and rehabilitation services
- Physician services
- Prescription drugs (Under fee-for-service reimbursement, prescription drugs will be subject to the national drug rebate program. Under capitated reimbursement, managed care rates will be developed based on fee-for-service drug expenditures, minus claimed drug rebates.)
- Preventative services – Annual physical exams, immunizations,, pap smears; mammograms, well-woman exams
- Skilled nursing facility – Benefits are limited to 120 days per calendar year, provided in full (subject to medical necessity)

There will be no yearly individual benefit maximum.

Current Medicaid budgeting and deduction rules for eligibility will apply to this covered group.

***Cost* Sharing**

Premiums at the time of services will apply to increase participant responsibility, move coverage closer to that found in the commercial market,, and help reduce the change of crowd out. Premiums will be $10 at the time of each provider visit and *$5* per prescription and the professional dispensing fee. These amounts were chosen because they are consistent with the state employee's health plan and with many other commercial plans. Failure to pay the cost sharing may result in denial of service.

Crowd Out Protections

While the issue of crowd out is not addressed in the Title XIX aw, we believe in today's health care environment it is important to address.

- Cost sharing is a significant "crowd out" protection. Since most private plans require cost sharing, even for people in minimum wage jobs, it makes no sense to eliminate them here. In fact, many commercial plans require *both* monthly premiums and co-pays at time of service. This would create the strongest of incentives to drop or avoid private coverage.
- Comparability – Move covered services close to that found in the commercial market. We are trying to move individuals into the mainstream, which includes a covered service package comparable to the commercial market. We have modeled our package after those in the state employee plan.
- Uninsured is defined as an individual who has not had employer-subsidized health care insurance coverage for six months prior to application for payment of health care.
- There will be a six month look back period for health insurance coverage when determining eligibility. If a person has been covered by health insurance in the last six months and dropped coverage, they will not be eligible for this program until six months after coverage was dropped. Exceptions to this limitation in cases where prior coverage ended due to reasons unrelated to the availability of government financed health insurance shall include, but not be limited to:
  - Loss of employment due to factors other than voluntary termination;
  - Change to a new employer that does not provide an option for dependent coverage; or
  - Expiration of COBRA coverage period.

Women's Health Services Under Title XIX

Covered Groups

Uninsured women losing their Medicaid eligibility 60 days after the birth of their child will be eligible for women's health services, regardless of income level, for a maximum of two consecutive years after their Medicaid eligibility expires. Eligibility will automatically be extended from the current 60 day period for the eligible population.

Covered **Services**

Women in this category are eligible for a two-year period for the following services only:

- Department of Health and Human Services approved methods of contraception;
- Pap test;
- Pelvic exams;
- Sexually transmitted disease testing and treatment;
- Family planning counseling/education on various methods of Girth control; or
- Drugs, supplies, or devices related to the women's health services described above when they are prescribed by a physician or advanced practice nurse (Under fee-for-service reimbursement, prescription drugs will be subject to the national drug rebate program. Under capitated reimbursement, managed care rates will be developed based on fee-for-service drug expenditures, minus claimed drug rebates.}

Cost Sharing

There will be no cost sharing for this coverage.

Crowd Out Protections

Crowd out is not believed to be a factor because of the very limited coverage and the fact that we know of no similar coverage available in the commercial market.

4.

A DETAILED PLAN FOR MONITORING THE STATE'S COORDINATION OF CARE, UTILIZATION, AND PAYMENT FOR OUT-OF-PLAN SERVICES.

The State of Missouri will coordinate the use of the new State Children's Health Insurance Program (Title XXI) funds to expand Medicaid coverage under this 1115 waiver. This creates the strongest possible coordination of the two programs to assure a seamless system of coverage and continuity of care. Families with children eligible under different categories or programs will not have to navigate different plans or provider networks.

Health coverage through the 1115 MC+ demonstration waiver allows for a continuation of transitional Medicaid with benefit and cost sharing changes which

allow us to communicate directly with current Temporary Assistance recipients for a smooth transition to this program. Coordination with traditional Medicaid is accomplished by using the MC+ 1915(b) program infrastructure and state eligibility system. This allows family members who qualify for MC+ based on differing criteria to remain in the same plans and networks.

For women's health services, coordination with current Medicaid will be seamless as this is an extension of services currently provided by Medicaid for an additional 24 months.

The MC+ managed care contracts with existing health plans detail the health plan's responsibility for coordination with out-of-plan services. The health plan is not obligated to provide or pay for any non-plan, non-capitated services, However, the health plan must agree to establish processes to coordinate in-plan service delivery with services delivered outside of the health plan. The Division of Medical Services will monitor each health plan's compliance with the coordination af out of plan services through contract compliance and quality assurance reviews. The major types of out-of-plan services with which it must coordinate are:

- School based services;
- Family planning;
- Public health program, mandated plan reimbursements;
- Childhood immunizations;
- Childhood lead poisoning prevention services including screening, diagnosis and treatment, and follow-up as indicated;
- Women, Infants, and Children (WIC) supplemental food program; and
- Comprehensive Substance Treatment Abuse and Rehabilitation (C-STAR).

5.

MARKETING AND OUTREACH STRATEGIES INCLUDING THE PERMISSIBLE MARKETING ACTIVITIES BY MCOs AND A COMPLETE DESCRIPTION OF THE ENROLLMENT BROKER.

Health plans are not permitted to practice door-to-door or fac ——— marketing campaigns or activities to solicit MC+ members. Indirect marketing activities are permitted within contract guidelines. Please refer to Attachment 2. During the enrollment process, the state will seek to identify MC+ members who speak a language other than English as their first language.

Uninsured Children Below 200 Percent Under Title XIX, Coordinated with Title XXI Funding

Outreach

Missouri will use brochures and informational flyers to educate families about the health coverage available through Medicaid. We will stress that:

- Children do not have to be on welfare (cash assistance) to be Medicaid eligible;
- Children may receive Medicaid benefits even if both parents live in the home; and
- One or both parents can work full-time and the children may still be Medicaid eligible.

The state will involve the MC+ Consumer Advisory Committee, the Division of Family Services income maintenance staff, the Department of Health, school districts, and other appropriate agencies or groups in the design and implementation of the brochures and flyers. We will continue to coordinate eligibility outreach efforts with schools, hospitals, and local health departments by identifying barriers to Medicaid access.

We will also move to a simplified mail-in application process for the expansion populations. This should overcome the burden of applying in person at a Division of Family Services office.

There will be cooperation with the Missouri Hospital Association in their efforts to develop an effective outreach program for not only this program, but for Medicaid children in general.

The State of Missouri has contracted with an enrollment broker to provider the services of a Health Benefits Manager (HBM). The HBM provides education, outreach, and enrollment activities for all MC+ eligibles. A copy of the current RFP for HBM services, shown as Attachment 3, fully describes the required activities for MC+ health plan enrollment.

TANF Transitional Adults for an Additional Two Years Under Title XIX

Outreach

We propose using brochures and informational flyers to educate families about the health coverage available through Medicaid. We will involve the MC+ Consumer Advisory Committee, the Division of Family Services income maintenance staff, the Department of Health, and other appropriate agencies or groups in the design and implementation of the brochures and flyers.

The primary outreach effort will be targeted at Temporary Assistance recipients as part of our efforts to help this population successfully obtain and maintain employment. The availability of continue health coverage will be stressed to them.

We will also move to a simplified mail-in application process for the expansion populations. This would overcome the burden of applying in person at a Division of Family Services office.

Uninsured Noncustodial Parents Below 100 Percent Paying Child Support Under Title XIX

Outreach

We propose using brochures and informational flyers to educate families about the health coverage available through Medicaid. We will stress that:

- Families do not have to be on welfare (cash assistance) to be Medicaid eligible;
- One or both parents can work full-time and still be eligible if they meet the low income test; and
- Parents paying and current on their child support can still be eligible if they meet the low income test.

We will involve the MC+ Consumer Advisory Committee, the Division of Family Services income maintenance staff, and other appropriate agencies or groups in the design and implementation of the mail-in eligibility process,

We will also move to a simplified mail-in application process for the expansion populations. This would overcome the burden of applying in person at a Division of Family Services office.

We will include information on the program with child support enforcement communications to this population.

Parents' Fair Share Under Title XIX

Outreach

Outreach will be part of the outreach for participation in Parents' Fair Share. We will involve the MC+ Consumer Advisory Committee, the Division of Child Support Enforcement, and other appropriate agencies or groups in the design and implementation of the mail-in eligibility process,

Uninsured Custodial Parents Below 100 Percent Under Title XIX

Outreach

We propose using brochures and informational flyers to educate families about the health coverage available through Medicaid. We will *stress* that:

- Families do not have to be on welfare (cash assistance) to be Medicaid eligible; and
- One or both parents can work full-time and still be eligible if they meet the low income test.

We will involve the MC+ Consumer Advisory Committee, the Division of Child Support Enforcement, and other appropriate agencies or groups in the design and implementation of the mail-in eligibility process.

We will also move to a simplified mail-in application process for the expansion populations. This would overcome the burden of applying in person at a Division of Family Services office.

Women's Health Services Under Title XIX

Outreach

We propose using brochures and informational flyers to educate the eligible population about the availability of services. Missouri already exceeds the national average as a percentage of births covered by Medicaid, and we will be extending this coverage to this population. Information about this extended service period will be added to the current successful material on coverage for pregnant women and the mandated 60 day post-partum coverage.

6.

A DESCRIPTION OF THE STATE'S BENEFICIARY EDUCATION PROCESS.

Prior to and after MC+ health plan and Primary Care Provider (PCP) selection, the HBM shall provide both written and verbal educational information to MC+ eligibles and enrollees regarding managed care and the MC+ program Education is provided through the following venues:

- Enrollment packet - Prior to enrollment, MC+ eligibles will receive an enrollment packet by mail which contains information including

available health plans and toll-free member hotline access, a description of plan benefits, listing of PCPs for each health plan, SSI opt out process, health plan transfer limitations, and the auto-assign process.

- Toll-free hotline access - The HBM maintains toll free access to hotline staff to provide information regarding the MC+ program, its benefits and the enrollment process. The hotline staff is trained by the state agency to provide the information necessary to assist MC+ eligibles in the health plan and PCP selection process. The HBM shall also provide education to MC+ enrollees after the selection process regarding any questions or issues that arise after enrollment into a health plan.
- MC+ eligibles outreach - The HBM shall provide outreach materials regarding the MC+ program and the enrollment process, as needed, in the form of brochures, flyers, posters, informational videos, public service announcements, and group presentations. If required by the state agency, the HBM will also provide community outreach in the form of group presentations using prior approved outreach materials.

Additional information regarding the specifics of the education process is included in the HBM RFP shown as Attachment 3.

7.

A COMPREHENSIVE DESCRIPTION OF THE ENROLLMENT AND DISENROLLMENT PROCESS WITH SPECIFICS ON THE DEFAULT ASSIGNMENT PROCESS.

A file of new eligibles is transmitted daily by the state agency to the HBM. The HBM will then mail an enrollment packet to the MC+ eligible containing the information needed to assist in health plan selection. The enrollment packet contains a mail-in application for plan selection, as well as a toll-free number to call if the member prefers to make their selection by telephone. If no selection is made within 15 days of MC+ eligibility approval, a selection will be made for the member. All members of a family will be assigned to the same health plan based on a pre-established auto-assign algorithm. The auto-assign process is established and performed by the state agency. A daily file of auto-assigned members is transmitted to the HBM and loaded into the HBM enrollment system. The HBM must mail a confirmation letter to all enrollees who have either made a selection or have been auto-assigned. The confirmation letter contains the family members' health plan selection or auto-assign, PCP selection, health plan effective date, and information regarding the members right to change health plans within 30 days from the health

Should be 10

plan effective date. If a person is MC+ eligible and does not choose a health plan, the person will be auto assigned to a health plan.

Disenrollment from MC+ occurs when a member is determined ineligible, is deceased, has moved out of the MC+ region, or has chosen to opt out of MC+ due to SSI eligibility. The effective date of disenrollment will vary depending upon the reason for ineligibility.

Changing Health Plans

Once a member chooses a health plan or is assigned to a health plan, he or she will have 90 days from the date the member receives notice of enrollment in which to change health plans for any reason. After the 90 day period, the member will be allowed to change health plans for any reason every 12 months thereafter. A notice will be provided at least 60 days before each annual enrollment opportunity. Members will have the right to change health plans for good cause as determined by the Department of Social Services at any time within the year.

8.

*SELECTION **POLICIES AND MCO** CONTRACTING **REQUIREMENTS***

Office of Administration, Division of Purchasing and Materials Management provides oversight of MC+ contracting with MC+ health plans. The Division of Purchasing uses a Request for Proposal (RFP) as the procurement method. Attachment 4 is a vendor manual that describes the purchasing policies and procedures utilized by the Division of Purchasing.

The offeror is advised that under the terms of the RFP, the Division of Purchasing reserves the right to conduct competitive negotiations of the proposal received. Proposals in negotiation are withheld from public record until award.

After determining that a proposal satisfies the mandatory requirements stated in the RFP, the comparative assessment of the relative benefits and deficiencies of the proposal is made using subjective judgment. The award of a contract is based upon the determination that all mandatory requirements in the RFP have been satisfied and that all capitation rates associated with a particular proposal are acceptable to the state and are determined to have actuarial soundness,

Any award of a contract resulting from the RFP will be made only by written authorization from the Division of Purchasing and Materials Management. The State of Missouri reserves the right to make multiple awards because of the volume of services that may be required.

9.

CAPITATION (INCLUDING RISK ADJUSTMENTS), INCENTIVE PLANS, AND CLAIMS PAYMENT MECHANISMS.

A portion of the expanded population will be covered under the Medicaid fee-for-service program in areas of the state not yet under managed cafe, This payment system allows self-referral to all health care providers enrolled with the Medicaid program. Health care providers submit claim forms directly to the Medicaid agency in order to be reimbursed for covered services.

In the areas of the state under managed care, the expanded population will be enrolled into health plans. The state shall make capitation payments to the health plan on a monthly basis via electronic funds transfer in the following manner:

- For each member enrolled on the first of the month, the state shall make a per member, per month payment as payment in full for any and all services provided to the member that constitute covered services. In exchange for the capitation payments, the health plan shall be liable or "at risk" for the costs of all covered services. The state's actuary prepares actuarially sound rate ranges for each of the rate categories. These rate ranges are within the upper payment limit for payments made under the Medicaid fee-for-service program, These are submitted to HCFA for review and approval.
- The capitation payment shall be equal to the amount awarded the health plan through the contract award process through a negotiated bid process. Negotiated rates must be actuarially sound as determined by the state.
- For members enrolled at any time after the beginning of the month's payment cycle, capitation for this month will be prorated and paid in arrears at the beginning of the following month.
- For members whose enrollment lapses for any period of a month in which a capitation payment was made due to loss of eligibility, death or other circumstance, the state shall adjust its next monthly capitation payment to recoup the portion of the capitation payment to which it is due a refund. The capitation payment adjustment will be prorated on a daily basis for those days which enrollment lapsed.
- The health plan must agree to accept capitation payments in this manner and must have written policies and procedures for receiving and processing capitation payments.
- The state will make a supplemental payment to health plans following delivery by a woman. The supplemental payment reimburses health plans for prenatal, delivery, and post-natal services costs not already reimbursed through the monthly capitation.

10.

MCO FINANCIAL AND SOLVENCY REPORTING, AND MONITORING REQUIREMENTS, INCLUDING STANDARDS FOR TIMELINESS OF CLAIMS PAYMENT.

The Missouri Department of Insurance regulates the financial stability of all licensed health plans in Missouri. The health plan, therefore, must agree to comply with all Department of Insurance standards.

Pursuant to Section 354.410.2(1)(2), RSMo:

> (1) The [deposit] amount for an organization that is beginning operation shall be the greater of : (a) five percent of its estimated expenditures for health care services for its first year of Operation, (b) twice its estimated average monthly uncovered expenditures for its first year of operation, or (c) one hundred fifty thousand dollars for a medical group/staff model, or three hundred thousand dollars for an individual practice association. . . .
>
> (2) Unless not applicable, an organization that is in operation on September 28, 1983, shall make a deposit equal to the larger of : (a) one percent of the preceding twelve months uncovered expenditures, or (b) one hundred fifty thousand dollars for a medical group/staff model, or three hundred thousand dollars for an individual practice association on the first day of the first calendar year beginning six months or more after September 28, 1983. . . .

Net Worth Requirements are found in the Missouri Code of State Regulations at 20 CSR 200-1.040:

> Ten percent of the average three-year projected premiums for the first full calendar year of operations. Thereafter, the minimum net worth shall be the greater of (a) two percent of annual premiums, or (b) one hundred fifty thousand dollars for a group/staff model, or three hundred thousand dollars for an individual practice association,

Payments to Providers

The state believes that one of the advantages of a managed care system is that it permits health plans and providers to enter into creative payment arrangements intended to encourage and reward effective utilization management and quality of care. The state therefore will give health plans and providers as much freedom as possible to negotiate mutually acceptable payment rates and payment time frames. All subcontracts shall contain the time frames for paying in-network providers for covered services. However, regardless of the specific arrangements it makes with providers, the health plan must make timely payments to both its contracted and non-contracted providers, subject to the conditions described below. All disputes between the health plan and contracted and non-contracted providers shall be solely between such providers and the health plan. If the state agency determines that the health plan is noncompliant with the conditions below, the health plan m y be subject to suspension of new enrollments, withholding in fufl or in part of capitation payments, contract termination, or refusal to contract in a future time period. It is agreed that in the case of any disputes regarding payment for covered services between the health plan and providers, the member shall not be charged for any of the disputed costs. This agreement shall only be overcome by written evidence of an agreement between the provider and the member indicating that the member accepts the status and liabilities of a private pay patient.

The health plans shall be responsible for paying at least 90 percent of ail clean claims from subcontractors for covered services within 30 days of receipt and paying at least 99 percent of all clean claims within 90 days of receipt, except to the extent subcontractors have agreed to later payment for medically necessary, covered services rendered by in-network providers when:

- Services were rendered to treat a medical emergency;
- Services were rendered under the terms of the health plan's contract with the provider;
- Services were prior authorized;
- Under these terms, the health plan will not be financially liable for services rendered to treat a non-emergent condition *in* a hospital emergency room or in other settings (except to the extent required elsewhere in law), unless the services were prior authorized or otherwise conformed to the terms of the health plan's contract with the provider.

The health plans shall be responsible for paying at least 90 percent of all clean claims from subcontractors for covered services within 30 days of receipt and paying at least 99 percent of all clean claims within 90 days of receipt to out-of-network providers for medically necessary, covered services when:

- Services were rendered to treat a medical emergency; or
- Services were prior authorized;

- Services were for family planning and sexually transmitted diseases;
- Under these terms, the health plan will not be financially liable for services rendered to treat a nonemergent condition in a hospital emergency room (except to the extent required elsewhere in law), unless the services were prior authorized.

Clean claim means a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

Health plans that have a pattern of inappropriately denying payments for services may be subject to suspension of new enrollments, withholding in full or in part of capitation payments, contract termination, or refusal to contract in a future time period.

77.

AN OVERALL QUALITY ASSURANCE MONITORING PLAN THAT INCLUDES A DISCUSSION OF ALL QUALITY INDICATORS TO BE EMPLOYED AND METHODOLOGY FOR MEASURING SUCH INDICATORS; SURVEYS TO BE CONDUCTED, AND THE MONITORING AND CORRECTIVE ACTION PLANS TO BE TRIGGERED BY THE SURVEYS; THE CREDENTIALING REQUIREMENTS AND MONITORING; FRAUD CONTROL PROVISIONS AND MONITORING; AND THE PROPOSED PROVIDER-ENROLLEE RATIOS, ACCESS STANDARDS ETC.

Access and Quality Measures

The purpose of a continuous quality and improvement process is to assure access to quality service in the MC+ program and the program for the expanded eligibles under the 1115 waiver program. The quality assessment measures contained in Missouri's Quality Assessment and Improvement Plan, included as Attachment 5, will employ a variety of methods and tools to measure outcomes of service that is provided. The goal is to monitor health care services provided to MC+ enrollees and waiver eligibles by the health plans and compliance with federal, state, and contract requirements. The health plans must meet program standards for quality improvement, systems, member services, provider services, record keeping, organizational structure, adequacy of personnel, access standards, and data reporting as outlined in the MC+ contracts. Quality control measures will be taken from the Health Plan Employer and Data Information Set (HEDIS) and other internally developed measurements. HEDIS is a strong public/private effort that includes a standardized set of measures to assess and encourage the continual improvement in the quality of health care. Specifically, Medicaid HEDIS includes additional quality and access measures which respond more directly to the needs of

women and children, who make up the majority of MC+ enrollees. Medicaid HEDIS is intended to be used collaboratively by the agency and managed care plans to:

- Provide the agency with information on the performance of the contracted health plans;
- Assist health plans in quality improvement efforts;
- Support emerging efforts to inform Medicaid clients about managed care plan performance; and
- Promote standardization of managed care plan reporting across the public and private sectors.

Contract Compliance Measures

Along with quality control/assessment, monitoring health plan compliance to contractual requirements is a primary method to measure whether the goals of managed care are being met. Contractual compliance monitoring begins with the issuance of the Request for Proposal (RFP) for the specific benefit package in question. The RFP contains standards for HMO licensure and solvency, network composition and access requirements, consumer protections, member services, primary care provider responsibilities, and other important requirements. Prior to contract awards, health plan proposals are reviewed and scored on the basis of cost, experience and reliability, expertise of personnel, and proposed method of performance by an interdepartmental team as part of the Office of Administration contract award process.

After contract award and prior to start-up, health plan provider networks are analyzed to assure adequate development of the provider network to meet the health care needs of Medicaid recipients. A readiness review is also conducted to assess the health plan's operational readiness to begin serving MC+ enrollees. The readiness review looks at each health plan's operations in member services, provider services, and quality assessment in an effort to assure health plans have adequate resources, such as numbers of primary care providers, contracts with hospitals and specialty providers, and client services staff, to meet the needs of their enrollees. Health plans are required to submit a provider demographic file so that MC+ enrollees will have access to important information about providers before they choose a health plan. With this information, recipients can choose between the different health plans' provider networks to assist them when making their very important choice of health plan. The file can tell recipients which primary care providers are available, along with the office locations and office hours. They can learn about the hospitals in each health plan as well as other specialty providers.

The division will continue to monitor contract compliance for the duration of the contract. This is measured through a variety of methods:

- Geographic accessibility (Geo Access) analysis tells the agency the percentage of Medicaid recipients who have access to particular providers within a specific mile radius.
- Annually the division reviews specific aspects of health plan operations. This may include health plan member services, provider services, quality assessment operations, and claims payment systems.
- Member satisfaction with the health plans is another method for measuring success of the MC+ program.
- Specific quality assessment measures include:
  - All quality assessment and improvement (QAI) reports are received within the 45 day due date;
  - All initial six month and annual QAI reports received from all health plans as required;
  - Auto assign rate, transfer numbers by region and health plan;
  - Numbers for new enrollment by region and reasons for leaving MC+;
  - Provider relations unit provides data on the number of calls concerned with MC+, provider/recipient comments/concerns, complaints, and positive comments; and
  - Consumer and provider feedback.

Fraud Control and Monitoring

The following definitions from state regulations pertain to the detection of fraud and abuse:

- Abuse – A documented pattern of inducing, furnishing, or otherwise causing a recipient to receive services or merchandise not otherwise required or requested by the recipient, attending physician or appropriate utilization review team; a committed pattern of performing and billing tests, examinations, patient visits, surgeries, drugs, or merchandise that exceeds limits or frequencies determined by the department for like practitioners, for which there is no demonstrable need, or for which the provider has created the need through ineffective services or merchandise previously rendered.
- Fraud – A known false representation, including the concealment of a material fact that provider knew or should have known through the usual conduct of his profession or occupation, upon which the provider claims reimbursement under the terms and conditions of a contract or provider agreement and the policies pertaining to such contract or provider agreement of the department or its divisions in carrying out the providing of services, or under any approved state plan authorized by the Federal Social Security Act.

The following procedures are required. Each health plan must establish procedures to identify abuse and/or fraud as relates to the Missouri Medicaid Program. These procedures will include the following:

- Training of health care plan staff to be aware of potential situations that may require further investigation by the health care plan, the type of information to obtain (if received as a referral). The health plan must identify a designated individual in the health care plan who is responsible for investigation and reporting systems.
- The health plan fraud and abuse procedures must be approved by the Missouri Medicaid agency. The health plan should seek to formalize a process to identify terminated, disciplined providers on a periodic basis. This process entails review of the HCFA sanction lists located on the Internet and communications from the Board of Healing Arts. A copy of the policy and procedure for fraud and abuse must be delivered to the state.
- A monthly report must be sent to the Missouri Medicaid agency which includes, but is not limited to, the health plan, the network provider, specific members, dates of service if identified in the initial complaint, summary of the complaint, investigation, and outcome. Instances of fraud/abuse may be audited by the state Medicaid agency or another authorized agency.
- The health plan must maintain all documentation related to the instances of fraud/abuse reviews/complaints/reports for five years, which is in accordance with documentation requirements contained within the Medicaid contract.
- The health plan must meet basic compliance with Medicaid regulations. The health plan is requested to provide an implementation plan for the sanction process to the state.
- The health plan must provide the minutes of any Credentials Committee Meeting in which terminated providers were reviewed. These minutes must indicate the action taken by the health plan. Also provide a list of sanctioned and terminated providers for the calendar year of 1997. This list must include the dates of services, the amount, and the date of recoupment.

Provider Enrollee Ratios

The state used the Academy of Family Practice Physicians Standard of 1500-2000 patients to 1 physician when setting the caseloads for primary care providers accepting enrollees. OB/GYN physicians are recommended to have caseloads of no more than 350 pregnant women.

An internal Medical Review Committee has been formed to provide review of issues, protocols, and complaints which require a clinical opinion. Forms used by the committee are included as Attachment *6:* The Record Request Form is used by

the Division of Medical Services Surveillance, Utilization, and Review Unit to request records from health plans and providers to be reviewed by the committee. The Request for Review Form includes the information which is necessary for the committee to begin the review process. Upon completion of the form the medical review process is initiated. Records of all requests are maintained and quarterly reports prepared which outline the request, committee decision, and health plan response.

A critical component in ensuring that the services being delivered to Missouri MC+ recipients are appropriate and of high quality is the independent external review of the process and the outcomes achieved. The purpose of the external review function is:

- To provide the state and federal governments an independent assessment of the balance between cost to provide services and quality of care and accessibility to health care delivered to Missouri MC+ recipients; and
- To identify problems in health care and contribute to improving the care of all Missouri MC+ risk-reimbursed HMOs.

Assessing the quality of care delivered to Missouri MC+ recipients includes a variety of analyses:

- What services are provided to the current Medicaid population and expanded population that have a major impact on the health status of the population being evaluated? That is, are the services being provided those services which should be provided?
- Are the services being provided by the health plans accessible? Are the health plans delivering the services at a quality level consistent with predetermined standards of practice? This includes a comparison of accepted treatment guidelines/protocols with actual treatment processes. It also compares actual access times for appointments, referrals, on-site waiting time, and knowledge of accessibility by MC+ participants with acceptable standards.
- Are the reports and data being collected by the Missouri MC+ program and the program for the expanded eligibles appropriate and sufficient to answer the above questions on a continuing basis?

Surveys to be Conducted

- First survey will be conducted within 15 months of implementation, and annually thereafter;
- Survey described within the operational protocol will be delivered to HCFA within 60 days prior to use;
- Each survey shall include:
  - Beneficiaries satisfaction with program administration

- Beneficiaries satisfaction with care provided
- Measures for the use of emergency rooms
- Waiting times for appointments (primary care and specialists)
- Access to specialty care providers

◆ Survey results will be delivered to HCFA by the 18th month of project implementation in accordance with Section E, Quality Assurance, Terms and Conditions.

All returned surveys are assessed to identify any areas which require follow up. Quality issues, access problems and complaints are targeted for immediate review. Medical records are requested if indicated. DMS staff attempt to contact all members, either by phone or letter, who request a return contact to obtain additional pertinent information. Recipient and health plan education is required to be provided by the health plan or DMS staff if indicated. All contacts,, investigation, education, and resolution information is documented and attached to the original survey response. Health plans receive data for each response to survey questions. The information is communicated for implementation into the Quality Improvement process. The state will monitor the effectiveness of corrective actions implemented through an audit process.

12.

SUBMIT A MINIMUM DATA SET, AND A DESCRIPTION SHOWING HOW COLLECTION OF PLAN ENCOUNTER DATA IS BEING IMPLEMENTED AND MONITORED; MEASURES THAT WILL BE IN PLACE FOR ENSURING ACCURACY, VALIDITY, AND TIMELY SUBMISSION OF DATA; WHAT RESOURCES WILL BE ASSIGNED TO THIS EFFORT; AND HOW THE STATE WILL USE THE ENCOUNTER DATA TO MONITOR IMPLEMENTATION OF THE PROJECT AND FEED FINDINGS DIRECTLY INTO PROGRAM CHANGE ON A TIMELY BASIS.

Encounters are required to be submitted within 90 days of the date of service or date of discharge. All health plans are required to submit all encounters electronically using the UB-92 layout for inpatient, outpatient, and home health; NSF HCFA-1500 for medical and dental; and NCPDP for pharmacy. The minimum data set for each file layout is shown as Attachment 7.

Encounters are subject to data validity, accuracy, and timeliness edits. A listing of these edits is shown as Attachment 8. If encounters post "fatal" data validity edits, they are returned electronically to the health plan with the error and description posted. Accepted encounters are also confirmed electronically. All accepted encounters submitted within a two week period are returned to the health plan electronically on the remittance advice.,

Encounter data reports are generated each weekly cycle and show all accepted encounters and error rates. The Contract Compliance Unit monitors the weekly report to determine if more than a 90 day period has elapsed in the submission of any claim category. If there has been more than a 90 day lapse in a claim type category, the health plan is notified in writing and corrective action requested. if appropriate corrective action is not taken, sanctions may be imposed.

A quality review sample is also done each month on all claim types to determine data integrity. Health plans are notified if anomalies or patterns of errors occur. On-going efforts continue to create appropriate means to monitor and ensure compliance with encounter data requirements.

13.

THE COMPLAINT, GRIEVANCE, AND APPEAL POLICIES THAT WILL BE IN PLACE A7 THE STATE AND MCO LEVEL.

MC+ program consumer protections include:

- Consumer satisfaction surveys;
- Complaint and fair hearing/grievance procedure (Attachment 9);
- Right to change health plans as allowed by federal law or for good cause as determined by the Department of Social Services;
- Right to change primary care providers, minimum of twice a year;
- Access and appointment standards;
- Prohibition against discrimination or separating MC+ enrollees from other patients;
- Marketing restrictions;
- Health plans must accept assigned members; prohibited from disenrolling;
- Member handbooks with multilingual access;
- Self-referral for mental health and family planning services; and
- Consumer advisory committee.

Recipient **Inquiries, Complaints, Grievances, and** Appeals

Health plan(s) will be required by contract to establish an inquiries, complaints, grievances, and appeals process that shall guarantee the right for a fair hearing to any member whose claim for medical assistance is denied, reduced, suspended, terminated, inappropriate to meet needs, or not acted upon properly by the health plan or the state agency. Through the grievance process, members can seek redress against health plans.

The following are MC+ definitions for inquiry, complaint, grievance and appeal:

- Inquiry – Request from a member for information that would: clarify health plan policy benefits, procedures, or any aspect of health plan function that may be in question. (Note: The health plan should develop policies and procedures that identify how inquir-ies are logged, the tracking of inquiries and identification of inquiry patterns;. tnquiries should be probed so as to validate the possibility of an inquiry actually being a complaint.)
- Complaint – A verbal or written expression by the member which indicates dissatisfaction or dispute with health plan policy, procedure, claims, or any aspect of health plan functions. (All complaints must be logged whether received by phone, in person, or in writing,)
- Grievance – A written request for further review of a member's complaint that remains unresolved after completion of the complaint process.
- Appeal - An appeal is the formal mechanism which allows a member the right to appeal a grievance decision.

A health plan's internal grievance procedures shall not be substituted for the current state process which provides an opportunity for a fair hearing before an impartial hearing officer to any person whose claim for assistance is denied or not acted upon promptly. The state Medicaid agency shall maintain an independent grievance procedure as required by federal law and regulation and allow beneficiaries direct access to a fair hearing as an appeal to the findings of the state's grievance process. The health plan must comply with decisions reached by the state's inquiries, complaint, grievance and appeal process.

Members shall have the right to file complaints and grievances with both the health plan and the state. These may be filed simultaneously, however, the state will encourage health plans and members to resolve complaints before the state takes action. A Consumer Advisory Committee formed by the state will assist in the development of educational materials and descriptions of grievance procedures. The composition of this committee will be representative of Missouri's Medicaid population.

The health plan's inquiry, complaint, grievance and appeal policies for recipient's shall:

- Be approved by the state.
- Utilize a standard form specified by the state agency for receipt of a grievance and acknowledgment by the health plan. Health plans must comply with the most current version developed by the state agency.

- Be distributed to all members upon enrollment, to all subcontractors at time of subcontract, and to non-contracting providers within 10 calendar'days of the date of receipt of claim.
- Name specific individuals who have authority to administer the grievance policy.
- Be approved by the health plan's governing body and be the direct responsibility of the governing body.
- Include a complaint and grievance system as well as an appeal process.
- Maintain records of all grievances and complaints and resolutions. The health plan shall retain records for five years following a final decision or close of the grievance. If any litigation, claim negotiation, audit, or other action involving the records has been started before the expiration of the five year period, the records shall be retained until completion of the action and the resolution of all issues which arise from it or until the end of the regular five year period, whichever is later.
- Resolve all urgent and emergency appointment complaints and emergency situations immediately or no later than two calendar days after filing of the complaint. All other complaints shall be resolved within 10 calendar days unless the original decision is appealed.
- The health plan must have the grievance procedures readily available at enrollment in the member's primary language. In addition, health plans must demonstrate that they have procedures in place to notify all members in their primary language of their rights to file grievances and appeal grievance decisions by the health plan.

The health plan(s) will be required to make the grievance procedures available orally and in writing in the recipient's primary language. The state Medicaid agency and the health plan shall inform members and applicants about both the health plan's internal grievance procedures and the state's grievance procedures at the time of initial enroliment, each time a service is denied,, reduced or terminated, or any other time of member or applicant dissatisfaction with the health plan. Summary information regarding nature of grievances and resolution may be publicly disclosed by the state in a consumer information book.

- If a health plan denies, reduces, or terminates a member's health service or requests the state to disenroll a member, it must notify the member or the member's authorized representatives in writing of the right to file a grievance. The notice shall explain:
  - How to file a complaint with the health plan, including the health plan's toll free customer services number;
  - How to file a complaint with the state, including the: Department of Insurance's consumer complaint hotline;

- That filing or resolving a complaint through a health plan's grievance mechanism is not a prerequisite to filing a state grievance;
- The right to a hearing as an appeal to a grievance decision reached through the state grievance process;
- That members may be advised or represented by a lay advocate, attorney, or other representative as chosen by the member and agreed to by the representative; and
- The right to request enrollment in another health plan through the grievance process if issue cannot be resolved.

◆ Any time a medical item or service is denied, terminated, or reduced, the recipient must receive written notification of the reason for the denial, reduction or termination.
- This written notification must be approved by the state agency.
- This written notification must include the member's right to access the complaint, grievance, and hearing process-
- o This written notification must be maintained with the medical records and kept for five years.
- This notification also includes prior authorization denials, drug prior authorization denials, and all other subcontractors.

Members can file complaints and grievances on any aspect of service provided to them by health plans or the member's chosen providers. Members may submit complaints and grievances, including those related to acts of cultural insensitivity that negatively impact on the member's ability to obtain care from the health plan, the Division of Medical Services, or both. The health plan complaint and grievance system shall consist of:

◆ A member services function, which members can use to ask questions, file complaints, and get problems resolved without going through the grievance process. The complaint process shall operate through either the filing of a verbal or written complaint within one year of the incident that results in a complaint. These complaints shall be resolved within 10 days of their filing. For health plans, the complaint process shall be completed before proceeding with a formal grievance. If a member is dissatisfied with the result of the complaint process, she or he may file a grievance in writing with the health plan within 90 days of the closure of the complaint process.

◆ A grievance process which members can use to file their dissatisfaction with the results of the complaint process. This process will require a written, substantiated complaint from members. The health plan shall reach decisions on grievances within 30 days of their filing date. Grievances shall be investigated by the health plan and reviewed by a designated authority within the health plan. Members have 90 days following written notification of the health plan's decision to appeal.

- Both members and health plans should attempt to resolve complaints through the complaint process before initiating a grievance. Health plans, as part of their complaint and grievance systems, shall:
  - Develop written policies and procedures which detail the operation of the complaint and grievance system including how to file a complaint or grievance. These policies and procedures shall be approved by the state prior to implementation.
  - Operate a member services function adequately staffed to receive telephone calls and meet personally with members,
  - Identify a person in the health plan who is specifically designated to receive and process formal grievances.
  - Distribute an information packet explaining the complaint and grievance system to members upon enrollment. This packet shall include the complaint and grievance system's policies and procedures, as well as specific instructions regarding how to contact the consumer relations office. It shall identify the person who handles grievances and provide simplified instructions on how to file a complaint or grievance.
  - Acknowledge the receipt of grievances in writing within 10 business days after receiving a grievance except in cases of emergency or when a grievance involves an access issue.
  - Operate an appeals process through which members can appeal any negative response to their grievances directly to the health plan's governing body. The governing body may delegate this authority to an appeal committee, but the delegation must be in writing.
  - Appeals must be filed in writing either by the member or the member's representative, or through the member's instruction to the health plan's representative that the member wishes to appeal. Appeals shall be filed directly with the health plan's board of directors or its delegated representatives and shall include an opportunity for members or their representatives to present their cases in person to the appellate body. The health plan shall reach a final decision on an appeal within 60 calendar days with extensions possible if approved by the state.
  - Maintain records of complaints that include a short, dated; summary of each of the questions or problems, name of the grievant, date of complaint, the response, and the resolution. If the health plan does not have a separate log for Medicaid recipients, the log shall distinguish Medicaid recipient members from other managed care health plan members.
  - Maintain grievance records that include a copy of the original grievance, the response, and the resolution. This system shall distinguish Medicaid recipients from other managed care health plan members and identify the grievant and the date of filing,

- At the time of health plan's initial decision regarding complaints and grievances, the health plan shall notify members of their right to appeal to both the health plan and the state.
- Assure that health plan executives with the authority to require corrective action are involved in the complaint and grievance process.
- Health plans must thoroughly investigate each grievance using applicable statutory, regulatory, and contractual provisions, as well as the health plan's written policies. All pertinent facts from all parties must be collected during the investigation.
- If the health plan's decision on a complaint or grievance is appealed to the state, all supporting documentation must be received by the state no later than five business days from the date the health plan receives notice of the appeal from the state. The appeal file shall include:
  - Written request of grievant asking for appeal.
  - Copies of the entire file that include investigation materials, medical records, health plan decision, and member's response. This file should contain both complaint and grievance materials.
  - Any information used by the health plan to reach its decision.
- Copies of the health plan's final written decision involving a grievance or an appeal shall be delivered by certified mail to the member.
- The health plan may use alternative resolution procedures to resolve both complaints and grievances. Both the member and the health plan must agree to use the alternative measure, and the state must be informed within two business days of a decision to use an alternative procedure. If a resolution is not reached within 30 calendar days using the alternative procedure, the complaint and grievance procedures above must be followed.

◆ Members, as part of the complaint and grievance system, may request transfers among providers within a health plan and disenrollment from one health plan and subsequent enrollment in another health plan.

- All disenrollment or transfer (those initiated outside of open enrollment or not for just cause) requests will be monitored and approved, or disapproved, by the state within 60 calendar days subject to medical record review. A copy of the member's medical records and supporting documentation must accompany all disenrollment and transfer requests.

◆ All transfers among health plans that members request during the first 30 calendar days following initial enrollment will be granted without review by the state. All transfers among health plans that members request during open enrollment times will be granted without review

by the state. Other times the state will review transfer requests. Members may request transfers among plans for good cause. Possible reasons for a member to request a transfer include, but are not limited to, dissatisfaction with:

- Enrollment – primary care provider or specialist whom recipient has an established patient/provider relationship no longer participates in the health plan but does participate in other health plan.
- An act of cultural insensitivity that negatively impacts on the member's ability to obtain care and cannot be resolved by health plan.

The health plans must also develop transfer policies that allow members to change primary care providers (PCPs) within the health plan. At least two such changes shall be allowed per year, and members will be informed of the process for initiating these changes. Possible reasons for a member to change primary care providers include, but are not limited to:

- Accessibility – transportation problems, provider office hours, does not return phone calls, waiting times.
- Acceptability – sees too many providers, uncomfortable with surroundings or location, provider or staff attitudes, lack of courtesy. Health plan should handle and recipient should file a grievance.
- Quality – treatment (medical), referral related, does not explain treatment plan/diagnosis. If provider problem, may request PCP changes and second opinion.
- Enrollment – primary care provider whom recipient has an established patient/provider relationship no longer participates in the health plan.
- An act of cultural insensitivity that negatively impact on the member's ability to obtain care.

Children in state custody or foster care placement will be allowed automatic and unlimited changes in health plan and provider choice as often as their foster care placement changes necessitate. Foster parents will normally have the decision making responsibility for which health plan will serve the foster child residing with them; however, there will be situations where the social service worker or the courts will select the health plan for a child in state custody or foster care placement.

All health plans must have written policies that address members" responsibilities for cooperating with those providing health care services- This written policy should address members' responsibilities for:

- Providing, to the extent possible, information needed by professional staff in caring for the member.
- Contacting their primary care provider as their first point of contact when needing medical care. .

- Following appointment scheduling processes.
- Following instructions and guidelines given by those providing health care services.

These member responsibility policies must be supplied to all providers and explained to all members.

Provider Inquiries, Complaints, and Grievances

Health plan(s) will be required to establish an inquiry, complaint, and grievance process that shall guarantee the right for a review to any provider of medical services for a member of that health plan. This will be a provider relations function.

The following are MC+ definitions for provider inquiries, complaints, and grievances:

- Inquiry – Request from a provider regarding information that would clarify plan policy benefits, procedures, or any aspect of plan function that may be in question.
- Complaint – A verbal or written expression by the provider which indicates dissatisfaction or dispute with plan policy, procedure, claims or any aspect of plan functions. All complaints must be logged and tracked whether received by telephone, in person or in writing.
- Grievance – A written request for further review of a provider's complaint that remains unresolved after completion of the complaint process.

The health plans inquiry, complaint, and grievance process for providers shall:

- Be approved by the state.
- Be distributed to all subcontractors at time of subcontract, and to non-contracting providers within 10 calendar days of the date of receipt of a claim.
- Be addressed in the provider handbook.
- Name specific individuals who have authority to administer the grievance process.
- Be approved by the health plan governing body and be the direct responsibility of the governing body.
- Maintain records of all provider complaints, grievances, and resolutions. The health plan shall retain records for five years following a final decision or close of a grievance. If any litigation, claim negotiation, audit or other action involving the records has been started before the expiration of the five year period, the records shall be retained until completion of the action and the resolution of all

issues which arise from it or until the end of the regular five yeas period, whichever is later.

- Resolve all urgent or emergency appointment complaints and emergency situations immediately or no later than two calendar days after filing the complaint. All other complaints shall be resolved within 10 calendar days unless the original decision is appealed..
- Must report provider complaints and grievances to the state agency in the format requested by the state agency.

14.

BASIC FEATURES OF THE ADMINISTRATIVE AND MANAGEMENT DATA SYSTEM.

The fiscal agent contracted by the state agency maintains a certified MMIS to process, collect, maintain, and report all encounter data, member enrollment data, health plan demographics, capitation rate tables, and reinsurance tracking system. The MMIS was modified to incorporate all related managed care processes in 1995. Modifications included the ability to:

- Accept and transmit health plan enrollment and disenrollment data – The MMIS receives enrollment and disenrollment data and transmits this information daily in an electronic format to the health plans.
- Accept and maintain health plan network data – The MMIS accepts daily electronic transmissions from the health plans containing additions, changes, and deletions to the health plan network demographics. This file contains all complete demographics an PCP, specialists, hospitals, pharmacies, and ancillary providers in the networks of each health plan. Select data from this file is maintained on the MMIS, then the entire file is transmitted to the enrollment broker to aid in the health plan selection process. Edits within the MMIS ensure that the minimum data set for provider demographics is complete and valid.
- Process, edit, and maintain encounter data – The MMIS accepts daily transmission of encounter data in standard layouts from the health plans. The MMIS edits for minimum data set completeness and validity. Twenty-four months of encounter data submissions are maintained on-line. A complete history of encounters over twenty-four months is maintained and available off line. Encounter data is maintained and available for a systematic and ad hoc reporting in a variety of formats and sort sequences.
- Make monthly capitation payments – Capitation rate tables are maintained within the MMIS for each health plan. Rates *are*

maintained by eligibility grouping and by age/sex cohorts within each grouping. Capitation payments are generated monthly based on current enrollment. Any changes to a member's enrollment period from the previous capitation cycle will be adjusted in the following capitation cycle.

- The MMIS contains a Reinsurance Tracking System which allows the tracking and accumulation of inpatient encounters by member, by health plan, by contract year. The reinsurance tracking system calculates inpatient expenditures by recipient that reach $50,000 or beyond. The system is able to create financial payouts based on the accumulated totals.

15.

DESCRIPTION Of ALL REFERRAL AUTHORIZATION PLANS, AND POLICIES AND PROCEDURES RELATING TO THEM.

Service accessibility standards are detailed in item 2.13 of the Central and Eastern Missouri MC+ RFPs, and Part II, Section II, paragragh 12 of the Western and Northwestern MC+ RFPs. Please refer to Attachment 2. The health plan must agree to provide coverage to members on a 24 hours per day, 7 days per week basis. The health plan must have written policies and procedures describing how members and providers *can* contact the health plan to receive individual instruction or authorization for treatment of an emergent or urgent medical problem and instruction regarding receiving care when the member is out of the plan's geographic area. The policies and procedures must be made available in an accessible format upon request. Direct contact with qualified clinical staff must be available through a toll-free member or provider services voice and telecommunication device for the deaf telephone number; recorded messages are not acceptable. The health plan must provide an accommodation, if needed, to ensure all health plan members equal access to twenty-four hour per day health care coverage.

The health plan shall ensure that prior authorization requirements are not applied to emergency medical services. Emergency medical services are those health care items and services furnished or required to evaluate and treat a sudden and unforeseen situation or occurrence or a sudden onset of a medical or behavioral condition manifesting itself by acute systems of sufficient severity (including severe pain) that the failure to provide immediate medical attention could reasonably be expected by a prudent lay person, possessing average knowledge of health and medicine, to result in:

- Placing the patient's health in serious jeopardy; or
- Permanent impairment of bodily functions; or

- Serious dysfunction of any bodily organ or part; or
- Injury to self or bodily harm to others;
- With respect to a pregnant woman who is having contractions: (I) that there is inadequate time to effect a safe transfer to another hospital before delivery or, **(2)** that transfer may pose a threat to the health or safety of the woman or the unborn child.

Plans must specify in writing their procedures for prior authorization of non-emergency services and the time frames in which authorizations wilt be processed (approved or denied) and providers and members are notified, The health plan will ensure that its prior authorization procedures meet the minimum requirement set forth in the MC+ contract.

If a health plan requires prior authorization for pharmacy products, the health plan must provide a response by telephone or other telecommunication device within 24 hours of a request for prior authorization. Approvals must be granted for any medically accepted use. Medically accepted use is to be defined as any use for a drug product which is approved under the Federal Food, Drug, and Cosmetic Act, which appears in peer-reviewed literature or which is accepted by one or more of the following compendia: The American Hospital Formulary Service -Drug Information, The American Medical Association Drug Evaluations, and the United States Pharmacopeia–Drug Information. Health plans must provide for the dispensing of at least a 72-hour supply of a drug product that requires prior authorization in an emergency situation.

16.

DESCRIPTION OF HOW BENEFICIARY ACCESS WILL BE GUARANTEED IN CASE OF TERMINATION OF THE MCO CONTRACT.

Requirements regarding termination of health plan contracts are detailed in item **2.31** and 3.14 of the Central and Eastern Missouri **MC+** RFPs, and in **Part II,** Section **IV,** and Part **III,** paragraph **15** of the Western and Northwestern **RFPs.** Please refer to Attachment 2. Upon expiration, termination, or cancellation of the contract, the contractor shall assist the state agency to insure an orderly transfer of responsibility and/or the continuity of those services required under the terms of the contract to an organization designated by the state agency.

Members enrolled in a health plan whose contract will be terminated with the state shall be informed of the process by which the members will continue to receive services. Members will be mailed an enrollment packet informing them of other health plan choices and the date by which they must choose prior to being auto assigned to an available health plan.

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DESCRIPTION Of THE BEHAVIORAL HEALTH REFERRAL SYSTEM, INCLUDING PROCESS, TIMELINES, INFORMATION EXCHANGE, COMPLAINT PROCEDURE, AND A PLAN FOR MONITORING THE EFFICIENCY OF THE SYSTEM.

To ensure continuity of care and the transition of managed care members who have received mental health services prior to entering the Missouri Medicaid managed care program (MC+), the state agency asks fee-for-service providers to contact the health plan selected by the recipient to make transition arrangements to the health plan. The health plan is responsible for transitioning the recipient and providing the immediate continuation of mental health services upon enrollment. Health plans are encouraged to authorize current providers to continue services for a period of time if services are needed to assure continuity of care. However, health plans may refer recipients to a health plan provider. The health plan must have written policies and procedures that permit members to seek in-network mental health services and substance abuse services without a referral or authorization from the primary care provider.

For behavioral health services to non-seriously mentally ill members the health plan shall be able to provide appointments as follows:

- Emergency within twenty-four (24) hours of request.
- Nonemergency within thirty (30) calendar days of request.
- Referrals when requested by a primary care provider (PCP) within 72 hours.

The health plan shall notify the member's PCP when a member is admitted for behavioral health services. Each health plan shall have protocols for coordinating care between the PCP and the behavioral health provider and indicate the expected response time for consults between the behavioral health and in-network provider. If a member will be transferred from a fee-for-service provider to a health plan provider, the health plan will secure from the fee-for-service provider the patient's behavioral health medical records in accordance with confidentiality guidelines.

Monitoring of the behavioral health referral system will be accomplished through audits performed by the Contract Compliance Unit and the Quality Assessment Unit of the Division of Medical Services. The Quality Assessment Unit requires annual reporting from each health plan on the following indicators:

- Mental Health Utilization – Percentage of members receiving inpatient/day/night care and ambulatory services.
- Follow-up after hospitalization for mental health disorders.

- Chemical Dependency Utilization – Percentage of members receiving inpatient/day/night care and ambulatory services.

In addition, the Quality Assessment Unit conducts on-site audits of the health plans including a review of the behavioral health services. The audits include a review of operational procedures for authorization/denial of services, referrals, care coordination, and communication between the health plan and the behavioral health providers. A thorough review of the utilization management and quality improvement programs is completed for the health plan and the behavioral health subcontractor. Periodic focused reviews may also be conducted based on inquiries, sentinel events, and/or other data coming to the attention of the Division of Medical Services.

18.

TRACKING AND REPORTING Of ADMINISTRATIVE COSTS.

Administrative costs will not be included in the budget neutrality limit. Claims for administrative costs will be made within two years after the calendar quarter in which they are made.

The standard Medicaid reporting process will be used during the demonstration. Missouri will continue to estimate matchable expenditures for the entire program (including the State Plan and MC+) on the quarterly Form HCFA-37. Missouri will provide schedules that clearly distinguish between estimates of expenditures subject to the budget neutrality cap (by major component) and estimates of expenditures that are not subject to the cap. Within 30 days after the end of each quarter, Missouri will submit the Form HCFA-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended.